STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined the facility failed to ensure that exits are readily available at all times. The finding included: Observation and testing on 7/15/13 at 10:16 AM of the cross corridor doors by the laundry revealed the door required more than fifteen pounds of force to open. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 7/15/13.	K 038	**K038**-Overseen by Maintenance Director, door was recalibrated and reset for ability to be opened with less than 15 pounds of force on 7/15/13. Overseen by Maintenance Director, all exit doors were tested and observed for opening ability on 7/15/13. All doors properly functioning. Overseen by Maintenance Director, QA will be conducted on testing and observing exit doors for opening ability. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to the QA Committee on 8/27/13. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	7/15/2013
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

M. Clark NHC — Administrator — 8/7/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 08 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	**825 FISHER AVE P O BOX 549** **SMITHVILLE, TN 37166**

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K 066	Continued From page 1 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. The finding included: Observation on 7/15/13 at 11:02 AM revealed there were no metal containers with self-closing cover devices into which ashtrays can be emptied in all areas where smoking is permitted. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 7/15/13.	K 066	**K066**-Overseen by Maintenance Director, an approved fire safe container with self-closing cover was ordered on 7/15/13. Item received and placed in smoking area on 7/19/13. Overseen by Maintenance Director, all staff inserviced on proper usage of fire safe container with self-closing cover by 8/6/13. Facility has one smoking area. Overseen by Maintenance Director, QA will be conducted to ensure proper functioning fire safe container with self-closing cover in designated smoking area. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to QA Committee on 8/27/13. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Informantion Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	**8/6/2013**
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 2 This STANDARD is not met as evidenced by: Based on testing and observation, it was determined the facility failed to ensure electrical wiring and equipment is in accordance with the National Electric Code. The finding included: Testing and observation on 7/15/13 at 10:42 AM revealed there were no Ground Fault Circuit Interrupter outlets adjacent to the sinks in the bathrooms of resident rooms 200 and 203. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 7/15/13.	K 147	K147-Overseen by Maintenance Director, outlets in affected rooms were replaced with Ground Fault Circuit Interrupter outlets on 7/26/13. Overseen by Maintenance Director, all resident rooms were observed and tested by 7/16/13 for ground fault circuit interrupter outlets. All other rooms and outlets in compliance. Overseen by Maintenance Director, QA will be conducted to ensure new outlets are functioning properly. QA will be conducted weekly for 3 weeks or until substantial compliance. Findings will be reported to QA Committee on 8/27/13. QA Committee consists of Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Assistant Director of Nursing, and Director of Rehab.	7/26/2013